



## Changes in Patterns of Health Care

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As a practical public health physician concerned mainly with the problems of the chronically ill and aged, I might seem somewhat out of place in speaking to a group mainly concerned with the opposite end of the age spectrum. But, people's values are often established during their childhood, and behavior for health is much influenced by early life experiences. I would remind you that chronic disease and disability is not confined to the adult and may even be manifested at birth, for instance, cerebral palsy, phenylketonuria and various other birth defects resulting in mental retardation or physical disabilities. Chronic diseases of the adult may well have their start during schooling, or even before, and may be prevented by influencing the school child's behavior. The best example is the large group of chronic diseases which are brought on by regular indulgence in smoking of cigarettes. Much cardiac and chronic respiratory disease might be avoided if we can find ways of indefinitely postponing the smoking habit.

We are accustomed to the ideas of health as a positive goal rather than as "control" of disease. We set as our goal not the absence of illness, but the physical, mental and social well-being of the individual. We have, I think, given up the stereotype of the clean-cut, athletic youth, male or female, with a

perfectly proportioned bronzed body and a winning smile. We recognize different somatotype and skin color, even within the same ethnic group. In a pluralistic society, such as ours, there can be no ideal physical shape or color toward which our youth should aspire. Even Hollywood has recognized a change in the ideal as portrayed by the American movie star. Today's screen heroes and heroines not only look different from the past but there is a wider range of types. This change has, in large part, sprung from the young people themselves. They have gone forward (or is it backward?) to long hair and sideburns or full beards for the men. Men's attire has once again become ornate and frilly, with women's dresses sometimes drab by comparison. I am no fashion expert, but it seems to me there are a number of conflicting tendencies. I see boys and girls dressed drably, and I see young men and women dressed similarly, so that it is sometimes quite difficult to distinguish the sexes by attire and hair styling.

It is not so much the outward fashion that counts, but the inward change in attitude and in behavior. Every age has its generation gap, but ours seems to be wider and deeper than most of the previous ones. There is a tremendous protest against authority on college campuses which has

filtered down to the high school and even the junior high school. The student protest is not confined to this country, but appears to be pandemic.

What is being protested? What effect has the protest had on values and behavior for health? The protest seems to be against the solid materialistic ideals of the business world, exemplified best, perhaps, by the phrase "rugged individualism." These ideals have given America the highest standard of living in the world. The protest is also against the hypocrisy of the same establishment which moralizes about the virtues of peace and the spiritual values of life, while condoning war and the pursuit of the dollar. Youth has taken the speeches of their fathers and the sermons of their pastors literally and has joined the poor and the disadvantaged in their fight for a better standard of living.

A particular form of this protest which has a very direct bearing on health is the hippie movement, which started some three years ago and is now a part of the scene in many large American cities. From being an idealistic withdrawal from a society which the young have rejected and a "help your neighbor," "make love, not war" movement, it seems to have degenerated into an irresponsible group seeking pleasure without restriction.



I have received a firsthand account of the kinds of problems that hippies have—as seen through the eyes of a physician in an agency which provides free health and counseling services. Their behavior is dictated to a large extent by a rejection of the values held by the establishment. They do not use tobacco or alcohol because they are establishment practices; they do not keep clean because the establishment thinks highly of cleanliness.

The hard core hippie makes a point of not working because conventional people work. Many, however, are only weekend hippies, working or going to college, and some are still in high school or even junior high school. In general, the latter group is simply looking for excitement or a good time during their free hours. The hard core hippie does not believe in birth control or abortion, but the weekend hippie readily accepts both. Since the establishment frowns upon loose sexual practices and the use of hallucinating or stimulating drugs for pleasure, these activities are a very large part of the hippie's behavior.

My physician friend has told me of some of the health problems of the hippies. Their main medical request is to have their gonorrhea treated. They do not seem to mind being re-infected, which often happens. They simply want to be treated for each infection. Many are severely mentally disturbed and ask for help. This particular clinic has a small number of psychiatric social workers and a psychiatrist, all of whom volunteers their time and does the best they can. Drug reactions are, of course, quite common among those who take any type of drug. Most of the hippies regard these as "bad trips" and are not discouraged by them. Recently, "potluck" parties have become popular, where many types of pills are mixed together and everyone takes a helping.

The babies born to hippies often have severe medical problems. Few of them ever see a doctor except in an emergency and few have had adequate immunization. They are, in general, inadequately nourished and many are given psychedelic drugs from infancy, the long-term effects of which are not yet known.

It seems that the original intellectual, idealistic hippies are probably a very small minority, and that most of today's group consists largely of high school dropouts who have left home and young vagrants who cannot hold down a job and have previously wandered from city to city, including some who have had previous psychiatric treatment and many who have spent some time in jail, usually for petty theft or vagrancy.

Such dropouts from school and society—are they not the end-products of our failure in education, in medical care, in psychiatry? Are they not the victims, very often, of what Menninger has called the "crimes of punishment?"

The established system of medical care is, for the most part, closed to the hippie. Many are under 18 and in most cities cannot receive medical care without parental consent, except in emergencies. They lack the money to go to a private physician and, in any case, are afraid of police involvement, because of drug abuse. They are usually ineligible for welfare because they have no fixed address, or are minors. For all of these reasons, they eschew official agencies and do not avail themselves of the free VD clinics or hospital outpatient services.

The medical problems of the hippies point up in an acute form the whole question of the availability to and utilization of the medical care system by those who need it most, namely, the poor. Studies have clearly shown that the poor in the United States receive a disproportionately low share of health services. There is a consistent pattern of low utilization of medical services by low income groups for each of the medical specialties. The proportion of the female population with obstetric or gynecologic visits in a one-year period increases sharply with increasing family income. Where family incomes are below \$2,000, only 2.8% have made such visits. At \$2,000 to \$3,999, 5.5%, and so on, up to 12.5% at family incomes of \$10,000 and above.

For visits to a pediatrician, the story is similar. At family incomes of under \$2,000, only 7.5% of the population under 17 made such a visit in the one-year period. At \$10,000

and above, the proportion was 33%.

The behavior of the poor with regard to dental visits is interesting. The pattern of visits to a dentist is similar to that of other specialists in that families with low incomes have fewer visits per year. A striking additional finding is the distribution according to type of service obtained when people do come for care. In the group under \$4,000, 26% of the visits that were made were for extractions and other surgery. This fraction decreased with increasing income until at incomes of \$10,000 and above, only 8.5% of the visits were for this purpose. Conversely, the higher income groups had a greater proportion of their visits devoted to cleaning of teeth and examination.

Why is there a difference in behavior between poor and rich with regard to medical care visits? Is it because the poor are healthier than the rich and do not need the services of physicians, dentists and optometrists to the same extent as the more affluent? Obviously, the contrary is true. A national health survey has reported that the number of chronic conditions and the annual experience of days per person of restricted activity, bed disability and time-loss from work are very much greater for persons with low family income. Furthermore, the poor have higher rates of hospitalization than the more affluent and their average length of stay is greater. These excessively lengthy stays may possibly be related to delay in obtaining treatment or to difficulties in arranging post-hospital care.

Can we say that poor do not value health as much as the more affluent? This is probably true, because the poor are concerned not just with health but with the many social and welfare problems which beset them. It takes information to know when and how to seek assistance for health problems; and the poor are not among the best informed in this respect. In our public health programs, we have noted that services which are available to all the population are quite often utilized more by the affluent than by the poor. There is, for example, a free service of throat cultures available to physicians for their office patients. This is intended to prevent rheumatic heart disease by the



early detection of streptococcal infection so that the physician can treat the condition promptly and adequately with penicillin. The service is utilized mostly in communities where there is a pediatrician, and these communities are among the more affluent in the state. The actual incidence of rheumatic fever, however, is highest among the low socioeconomic population, the people who use the service least. Where services are utilized, for example, in hospitals and clinics, the poor are often made to wait an inordinately long time before they can see a physician, and then quite often are dealt with rather summarily. Until recently, the disadvantaged accepted such conditions and made use of the services on an emergency basis only. However, behavior is changing and minority groups are demanding that they be treated in a more dignified manner and that the service they receive be of high quality. Since so many of the poor are black, and such a high proportion of blacks are poor, this movement has tended to be looked upon as a militant black movement, but in areas where blacks are not in the majority, we find the same agitation among other disadvantaged minority groups.

This had led health administrators to think of more acceptable ways of reaching people who would not otherwise avail themselves of health programs. Such a technique is being used with the Pap smear, which is a screening test to detect cancer at such an early stage that it can actually be cured. It is, therefore, important to get women to have this test, and it would seem that they should come to the screening clinic. However, those most at risk are those who are least likely to visit the clinic, since the highest prevalence of this type of cancer is found among the lowest socioeconomic groups of women, and particularly among those who marry early and have large families. A test has now been devised which can be taken to the woman's house or, in a different kind of setting, be given to a woman to mail back to the clinic. In some areas, neighborhood aides are being trained to take this test into people's homes and to explain to women how to use it. The aide then inspects it to see that it has been

taken properly and brings it back to the clinic. In this way, cases of early cancer are being detected and prevented in a group of people who under ordinary circumstances would not be reached.

We are coming around to believe that health is not a privilege but the right of every person. I have noted the differences between people and the fact that there is no ideal physical, or for that matter, psychological type. Each person is unique, as R. H. Tawney, in his essay on "Equality," says, "without regard to the vulgar irrelevancies of class and income." He goes on to say that in spite of their varying characters and capacities, "men possess in their common humanity a quality which is worth cultivating." To further quote Tawney, "Nature, with her lamentable indifference to the maxims of philosophers, has arranged that certain things, such as light, fresh air, warmth, rest and food, shall be equally necessary to all her children, with the result that, unless they have equal access to them, they can hardly be said to have equal rights, since some of them will die before the rights can be exercised, and others will be to enfeebled to exercise them effectively."

### **HEALTH IS A PREREQUISITE TO EQUALITY OF OPPORTUNITY**

The importance of health as one of the pillars on which equality of opportunity must be based was recognized by the 89<sup>th</sup> Congress when it passed 12 major pieces of health legislation, including Medicare, the Comprehensive Health Planning Act, the Heart, Cancer, Stroke, and Related diseases Program, and by the Office of Employment Opportunity with its neighborhood health centers and Head Start.

Officially, then, in the last Administration, health has had a very high priority. However, it is not easy to change the direction in which large organizations for so long have been headed. That this was recognized by the previous Administration was illustrated by the "Comprehensive Health Planning Act," which was signed into law in November 1966, setting forth as a national goal "the highest level of health obtainable for every person."

In order to ensure comprehensive health planning, with an emphasis on planning, it would seem that this afforded an opportunity for a clean sweep and a new start. Theoretically, with the use of new techniques, it would be possible to find out what really are the health needs of a community and then to see what kinds of organizations, agencies and services are required to meet those needs. However, the same comprehensive health planning law which called for a new or modified system for delivery of services at the same time declared that planning should not interfere with existing patterns of private professional practice of medicine or dentistry and related healing arts. As Jacobs and Froh pointed out in an article on the Comprehensive Health Planning Law in the *New England Journal of Medicine*, "it is difficult to conceive of any change in the health system that will not affect the current practice of health professionals." They go on to say, "The courts may be required to differentiate what is progress in the delivery of health services from what is interference in professional practice."

The Comprehensive Health Planning Act calls for the formation of area-wide planning councils, with consumers of health services making up more than half of the Council. A rather new concept in the organization of government-sponsored health services, it is in step with the demand of disadvantaged groups to have a say in the policy decisions of institutions and programs which provide service to their people.

It has come of something of a shock for the professionals to have to share committee rooms with their patients and it may be that in some areas the pendulum has swung too far, with the uninformed layman telling his professional superiors how services should be planned and operated. Too often, however, agencies have been operated for the convenience of the medical, nursing and technical staff rather than for the community they service. We are learning to see things from the consumer's point of view: what it means, for example, to have a medically excellent outpatient service located in a hospital across the city, so that a mother with



one or more children in tow has to make the tedious journey by public transport, involving, usually, at least one transfer, and then spend one, two, or three hours in a waiting room before being able to see the doctor. Under these circumstances, follow-up visits are neglected.

As we begin to see things from the patient's point of view, doctors and nurses are moving into ghetto areas and more and more satellite clinics or neighborhood health centers are being opened for the benefit of the lower socioeconomic community.

Does bringing the services to the people actually result in a health gain to the people? We can examine the progress of what I think is the very first; the prototype of the neighborhood health center. It is in Columbia Point, Boston.

Columbia Point is a public housing development which was opened in 1954 on a peninsula jutting into Boston Harbor. It was formerly the city dump and soon had a reputation as the least desirable public housing in the city. Despite a severe shortage of housing, it was difficult to keep filled. The community of 6,000 was half white, half black, and 40 percent were on public welfare. Monotony, isolation and barrenness inevitably produced a sense of apathy and helplessness in the population. Only 15% of the residents belonged to any of the 21 organizations in the community.

Several months were spent in the explaining the purpose of the proposed center and obtaining community participation. Eventually, a representative board of 24 directors for the new Columbia Point Health Association emerged from these meetings. Over half of the Board had never before belonged to any organization.

In the meantime, the Housing Authority furnished 12 rent-free apartments in the center of the community, and in December 1965 the Department of Preventative Medicine of Tufts Medical School was funded by the Office of Economic Opportunity to set up a prototype of the neighborhood health center. It is currently funded through ABCD (Action for Boston Community Development), the city's anti-poverty agency.

The effects of placing a comprehensive ambulatory health center in the middle of an isolated low-income public housing development have been nothing short of astonishing. Hospital admissions are only one quarter of what they were in the year before the center was opened. This amazing reduction was not, as you might perhaps speculate, accompanied by an increase in average hospital stay for each admission. It's quite the reverse, in fact. The total number of hospital days for Columbia Point patients was only one fifth of what they were formerly, that is, down by 80%.

That this is no isolated phenomenon can be seen by examining reports from other neighborhood health centers. For instance, Providence, Rhode Island, has more recently established a health center which provides good ambulatory care, but not as comprehensive as that provided by Columbia Point. Already, hospital admissions and stays are half of what they were before its establishment. (The results of two years' experience have been reported in the *New England Journal of Medicine*.)

The Columbia Point and Providence experiences show that under certain circumstances the poor do value health, and that their behavior toward health services can change from negative to positive.

The Health Center is now operated jointly by the Board and the Medical School. The going was not easy; the Board members' long experience with clinics made them skeptical and the professionals tended to resent much of the helpful advice from community members.

I am sure that this pattern of behavior will be repeated throughout the country. We will also see a good deal of wrangling between community groups and the providers of services; that is, the hospitals, home health agencies, rehabilitation centers, etc. This, to my mind, is a healthy thing. The old system, by which services were planned as a blueprint without any participation from the community, is, I believe, a thing of the past. There will need to be, as there has been in Columbia Point and other neighborhood health centers, a contractual agreement be-

tween the professionals who are providing the services and the representatives of the neighborhood who are receiving the services. The professionals want a service with high standards, using only the best trained staff and the best equipment. The community very often wants a service which will be for convenience of the community; so that they will not be kept waiting long and there will be someone to look after their children. They would also like to have neighborhood people employed by the service, which can lead to difficulties since it raises a threat of lowering professional standards.

This means a system analysis approach to many medical and allied health occupations. There are numerous tasks which a doctor does which can be done by a nurse or a technician. There are many tasks which a nurse does that can be done by a nurse's aide, and so on. Is it necessary, for example, for a physician to take a Pap smear on a woman? Can a nurse carry this out? The answer is yes.

Bringing services to people and planning with people are concepts which are common to a number of government-sponsored programs. The Regional Medical Program, also called the Heart, Cancer, Stroke Program, provides federal funds to the practicing physician the skills acquired in "centers of excellence," mostly the medical school hospitals. Advances in medical diagnosis and therapy are going forward at an accelerated rate, and there is a tendency for the busy physician in private practice to be left behind. The organization required to bring this about is required by law to be regional, rather than federal or state, so that it need not be hampered by irrelevant political boundaries.

The Model City Programs have a similar intent on a smaller geographic scale, but with more concentration for change, for people in run-down city areas which can be rehabilitated.

We are living in a time of changes at all levels, federal, state and local; in demands by people; and in changes thrust upon us by the march of technology. The more populous this country and the world be-



come, the more complex the organization of society becomes.

One way of attempting to deal with a complex society is through strong central planning and direction. Fortunately, in our culture, we seem to be coming around to the opposite conclusion – that the planning and control of health services should be local; the population presumably being dependent on the kinds of health needs to be met.

Formerly, except for the control of the contagious diseases, public health was not concerned with personal health services. The important elements of a public health service consisted of the provision of a pure water supply, the sanitary disposal of waste matter, the policing of food stores and restaurants, etc. That these factors have been dealt with effectively can be gauged from the fact that the three leading causes of death in 1900 were influenza and pneumonia, tuberculosis, and gastroenteritis—all three of them, infectious diseases which then accounted for 54% of all deaths now account for less than 4%. The three leading causes

of death today are heart disease, cancer and stroke, which account for 63% of all deaths. At the same time, the expectation of life at birth has risen from 49 years in 1900 to 70 years today.

That this is no cause for complacency may be judged by the fact that the United States ranks fourteenth in infant mortality, with a rate of 25 deaths per 1,000 live births, compared with only 12 for Sweden, the top ranking country, and 18 for Japan, which has made enormous strides in recent years. Our low rating is due to the high infant mortality among our underprivileged.

Even our much-vaunted longevity leaves something to be desired. Seven nations have longer expectation of life than the United States. In the Netherlands, Norway and Sweden, the expectation of life is two years longer than ours. Here, too, our national average is pulled downward by our collective neglect of the poorer sections of our population.

The health of our nation would be improved if we could assist the underprivileged

to make better use of improved health services. That that can be done has been proven by the neighborhood health center concept. That there are other ways of doing it has been shown by such programs as Head Start. Provided that there is sufficient support in funds and interest by government and legislature, the poor and the professionals in equal partnership will, I believe, come up with other effective ways of improving their health indexes.

There still remains the problem exemplified by the hippie. How do we motivate people to adopt habits of living which promote good physical, mental and social health? How do we get people to realize their potential for a satisfying and rewarding life? How do we persuade people of different cultures and outlooks to work for a common good and, for that matter, agree on what is the common good? Perhaps if we put a priority on improving those indexes of health which we can measure quantitatively, we will have made a good start in dealing with other social problems.